

Research Update is published by the Butler Center for Research to share significant scientific findings from the field of addiction treatment research.

RESEARCH UPDATE

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Depression, Suicide, and Addiction

Sadness, despair, and depression are prevalent problems among alcoholics and addicts. It can be difficult to differentiate the clinical syndrome of major depressive disorder from the emotional turbulence of addiction for any of the following reasons:

- Many drugs themselves are depressants, including alcohol, sedatives, and minor tranquilizers.
- Alcohol or drugs may provide a chemical cushion or buffer to ward off the emotional impact of everyday events. Without the drug, a person experiences feelings again, some painful, that the person may misidentify as abnormal.
- Many apparent symptoms of depression appear during normal withdrawal from drugs. For example, cocaine addicts typically experience a "crash" three to five days after their last use.
- The normal course of addiction may have brought about many tragedies (divorce, loss of custody of children, fatal car accidents) that cause intense but normal grief.
- Loss of the relationship with the drug of choice causes grief. Alcohol or other drugs often becomes a "best friend" that is always there to provide solace and relief.

Prevalence of Depression

Most research suggests that the rate of major depressive disorder is 2-4 times higher among alcoholics and addicts than in the general population, with rates of about 30%-40% among people seeking help for alcohol and drug problems.^{1,2} The correspondence is higher between dependence and depression (as opposed to abuse) and higher for drugs other than alcohol.³ The association between depression and alcohol/drug problems increases with age.⁴

As in the general population, the rate of depression among female alcoholics and addicts is about twice as high as in males.⁴ There seems to be an especially large overlap between addiction and bipolar illness (or manic depressive disorder), with the rate of bipolar illness three times higher in treatment populations (3% vs. 1%).⁵

Depression in Treatment and Recovery

Careful differential diagnosis is critical. A study that tracked depressive symptoms in alcoholic men during alcohol treatment found that, while 67% of alcoholics with a primary diagnosis of depression remained depressed four weeks later, none of the alcoholics with a secondary diagnosis of depression showed symptoms of depression.⁶ In this study, primary and secondary referred to the timing of the disorders. If depression preceded alcoholism, it was likely to remain even after sobriety; if the alcoholism came first, depression was likely to subside. In actual practice it is difficult at best to differentiate between primary and secondary depression. While this study had a small sample size, the results of this study do suggest that there is no "one size fits all" approach to depression.

Typically, depression in alcoholism or addiction is treated with psychotherapy and, often, antidepressants. Studies have demonstrated that antidepressant therapy is effective in reducing depression among alcoholics.² The use of antidepressants is understood and supported by Alcoholics Anonymous.⁶ However, it is important that medication is part of the treatment plan (and not a replacement for it), and does not supplant the work of recovery.⁷

THE HAZELDEN EXPERIENCE

A significant proportion of patients treated at Hazelden for alcohol and drug problems also have a diagnosis of depression. For example, at Hazelden's Center City facility during the 12 month period between October, 1998 and October, 1999, almost one-third (30%) of the patients had a concomitant major depressive disorder. About one-fourth (23%) were diagnosed as having a milder form of depression or a substance-induced mood disorder. About 7% were diagnosed with some type of bipolar illness. These rates of depression are similar to what is reported in the research for people seeking help for alcohol/drug problems. Mental health treatment for these co-existing disorders is individualized, incorporated into the treatment process, and may include psychotherapy or medication.

CONTROVERSIES & QUESTIONS

"I thought that successful recovery means being drug free and people should not use medications like antidepressants." Antidepressants are an acceptable and effective treatment method for depression. Cognitive behavioral psychotherapy and some lifestyle changes are effective treatment methods for depression as well.⁸ Some alcoholics and addicts may prefer to first try non-medication methods to treat their depression. However, it is a mistake to go to the opposite extreme, avoiding the use of antidepressants in the face of serious, unremitting depression.

HOW TO USE THIS INFORMATION

Alcoholics and addicts with depression need longer-term assessment, treatment, and continuing care. The interaction of the two disorders is complex in that one may mask the other, and during the recovery phase, relapse of one may trigger relapse to the other. Both disorders need to be addressed, together, over an extended time period.

Depression may prevent a person from establishing a stable recovery from addiction. Any alcoholic or addict who remains depressed after becoming sober should seek help; being depressed is not a sign of weakness or of not working the Twelve Step program well enough. Suicide risk needs to be carefully monitored.

Depression, Suicide, and Addiction



Results of outcome studies provide no definitive answers about the effect of depression on the course of alcoholism or addiction. Some studies show worse outcomes, some show no effect, and some, remarkably, show better outcomes.⁸ It may be that results differ according to the validity or homogeneity of the diagnosis of depression, and the extent to which depression is treated during the alcohol/drug treatment episode.

Suicide, Depression, and Addiction

Suicide is a tragic consequence of depression. According to the Centers for Disease Control and Prevention, suicide took the lives of 30,535 Americans in 1997 (11.4 per 100,000 population).⁹ Overall, suicide is the eighth leading cause of death for all Americans, and is the third leading cause of death for young people aged 15-24.¹⁰ Suicide rates are higher among men than women.

A history of alcohol/drug use disorders is a major risk factor for suicide.¹¹ In a variety of studies, unemployment, interpersonal loss, hopelessness, recent physical illness, family history of alcoholism, and childhood trauma have appeared in various combinations as additional risk factors.¹² It is generally agreed, however, that "the combination of depression and alcohol use disorders is particularly lethal, conferring a higher risk of suicide than any other clinical or demographic predictor."¹³ Suicide attempts may be associated with higher addiction severity and use of more substances.¹⁴

Aaron T. Beck,¹⁵ a major researcher in the field of depression, did a series of studies examining the relationship between suicide and addiction. Overall, he found alcoholics who completed suicide had a higher degree of hopelessness, lethality, and the intent not to be discovered during their plans. A study of the blood alcohol levels of people who completed suicides also shows the connection between alcoholism and suicide: A review of 19,347 deaths from 331 medical examiner reports from 1975 to 1995 found that almost one-fourth (22.7%) were determined to have been intoxicated at the time of death.¹⁶

Early sobriety is a high-risk time for suicide, in that individuals may be more cognitively clear and capable of carrying out suicidal thoughts than they were during the active phase of their addiction.¹

This text was prepared particularly in memory of Nicholas Thayer Fisher by his family and those who loved him.

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Patricia Owen, Ph.D., Director

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